CONNECTICUT ASSOCIATION FOR
HEALTHCARE AT HOME℠

TESTIMONY

Provided by Deborah R. Hoyt, President and CEO
The Connecticut Association for Healthcare at Home

Government Administration and Elections Committee
Public Hearing

February 25, 2015

IN SUPPORT: HB 5816 AN ACT CONCERNING AUDITS BY STATE AGENCIES

*That the general statutes be amended to **preclude agencies from using the methodology of extrapolation when conducting audits of state-funded entities** unless there is a sustained or high level of payment error or evidence of fraud.*

Good afternoon Senator Cassano, Representative Jutila and members of the Government Administration and Elections Committee. My name is Deborah Hoyt, President and CEO of the Connecticut Association for Healthcare at Home.

The Association represents 62 licensed home health and hospice agencies that foster cost-effective, person-centered healthcare for the Connecticut's Medicaid population in the setting they prefer most – their own homes.

The Association and our member agencies collaborate closely with the Department of Social Services (DSS) and are an integral part of achieving the State's Long Term Care goals of Aging in Place and rebalancing through the Money Follows the Person (MFP) Program.

We ensure that chronic conditions of the Medicaid frail elderly, disabled, and homebound are managed and their healthcare is coordinated across the provider continuum. Connecticut home health agencies are major employers with a growing workforce and an "on-the-ground army" of approximately 17,500 employees.

We appreciate your interest in hearing the provider perspective and raising **HB 6550 5816 AN ACT CONCERNING AUDITS BY STATE AGENCIES.**

Connecticut's licensed home health agencies work diligently to comply with Medicaid provider regulations. We fully agree that a fair and effective audit process is important to the integrity of the Medicaid program and to eliminate fraudulent billing practices.

Medicaid audit education and compliance by our member providers is a constant focus and priority. We take pride in the ethical practices of our member agencies

and their commitment to serving the state Medicaid population despite the challenges they face in underfunding and inadequate reimbursement.

I have met with DSS and the audit team and appreciate their efforts in increasing provider education and audit process transparency through the creation of protocols for home health and home care providers. The Association has submitted input to the protocols recently drafted by DSS and is awaiting the opportunity to meet with them to discuss our recommended edits.

Additionally, the CT Association for Healthcare at Home participated in the drafting of a comprehensive list of provider audit concerns with the Association Collaborative. Extrapolation and the definition of "clerical errors" are a concern as well as the need for effective audit exit interviews and appropriate initial audit finding letters.

We strongly believe that effective exit interviews that identify additional documents required prior to the auditors leaving the facility, and the discussion of early findings would improve the process and create efficiencies for both the audit division and the agency provider.

Home health providers also deserve accurate initial finding letters – a document that is a liability for the agency in terms of potential monies owed to the state. While the initial letter may not correspond to the final dollar amount due, the providers share the finding letter with the agency's board of directors, banks, business partners and others. We have heard that some initial finding letters reported millions in monies owed, while after meeting with DSS and providing the required document, a payment of only a few thousand dollars was actually owed.

Extrapolation is generally the reason for the inflated initial finding letters, resulting in legal fees for the provider agency, a diversion of staff resources from clinical care to documentation, and undue stress on the provider network.

The coalition's recommendations communicated to DSS are outlined below.

Extrapolation

Extrapolation is a statistical technique for inferring what occurred outside the range of what was actually measured, and should not be used in the following circumstances:

1. **Across Disparate Services:** Do not extrapolate across disparate services, apply only to like claims.
2. **ED vs. Non-ED Claims:** Claims related to emergency medical care should not be extrapolated to claims not related to emergency care.
3. **Observation Care:** Claims for any appropriate medical care for anyone in observation status after 23 hours.

4. **Clerical Errors**: Circumstances involving a clerical error, especially when there was no financial impact resulting from the error.
5. **Unintentional Overlap in Services**: When two unrelated providers submit claims for serving Medicaid clients during the same time period, caused by circumstances beyond their control.
6. **Transition to New Billing Procedures**: When payment or billing errors result from a transition to a new billing procedure.
7. **Prior to Policy Effective Date**: When claims were submitted prior to the issuance of the specific audit and/or reimbursement policy that is the subject of the audit.
8. **No Notice of Service Plan Amendment**: When the provider demonstrates that it was not made aware of a plan amendment prior to providing the service.
9. **Unique or Rarely Used Claims**: Unique claims should be dealt with individually.
10. **Outlier Claims**: Outlier claims should be dealt with individually.

Sampling Methodology

Extrapolation projections must be based on a statistically valid random sample, as reviewed by a statistician or by a person with equivalent expertise in probability sampling and estimation methods.

1. **Early Disclosure of Sampling Methodology**: The methodology should be disclosed at the outset of the audit.
2. **Sample Stratification**: Claims should only be pulled that are specific to the procedure or service identified by the CPT code.
3. **Use of Median vs. Average**: The median should be applied in cases in which claims with multiple services are being extrapolated to reduce the overweighting of multiple claims.
4. **Paid Claims Only**: The universe of claims to be sampled cannot exclude claims for which no payment was issued.

Fairness of the Audit Process

These measures should be implemented to ensure the fairness of the audit process:

1. **Compliance with Federal and State Rules**: A provider should be permitted to raise, at any time, including as an item of aggrievement, that its compliance with a state or federal law or regulation explains or negates a negative finding in an audit.
2. **Additional Information to be Provided by the Auditor**: Auditors should provide the following information regarding audit activities:
    a. At the commencement of the audit:
        i. The name and contact information of the specific auditor(s);
        ii. The audit location – either on site or through record submission;
        iii. The manner by which information shall be submitted; and
        iv. The sampling methodology to be employed in the audit.
    b. When extrapolation is used, the formula and data/claims used in the sampling shall be provided to the provider and disclosed in the audit report.
3. **Auditor Qualifications**: Auditors must undergo training and possess certain qualifications:

   a. Auditors must have coding experience, including but not limited to applicable ICD, CPT, and HCPCS codes.
   b. Decisions regarding medical necessity must be made by a professional licensed in the same clinical discipline.
   c. Auditors must have general knowledge of the particular provider services under audit and the Medicaid program they are auditing.
   d. Sampling methodology must be reviewed by a statistician, or by a person with equivalent expertise in probability sampling and estimate methods.

4. **Composition of the Audit Team**: The team must include qualified individuals, such as medical or dental professionals experienced in treatment, billing, and coding procedures.
5. **Appeals:** The audit appeals process should include at least 2 levels: (1) the initial request for reconsideration and (2) a second level appeal to an external party.
6. **No Recoupment While Appeal is pending**: A provider will not be subject to alleged overpayment, re-payments, or recoupment while an appeal is pending.
7. **Look-Back Period:** Expressly limit the "look-back" period for audits to claims that are not more than two years from the date the claim was filed.
8. **Timing and Frequency of Audits:** Achieve greater transparency in the scheduling and frequency of audits. The Department should complete the audit report in a timely fashion.
9. **Conference before Issuing a Preliminary Written Report**: When an extrapolated figure exceeds $200,000, a conference must be held before the auditor issues a preliminary written report.
10. **Comparison of Preliminary Audit Findings vs. Final Written Report**: Publish an annual report comparing de-identified audit findings included in preliminary written reports against those included in final audit reports.

Medicaid home health care provided by the state's licensed agencies ***is*** the cost effective means of delivering care and achieving significant cost savings to the state's annual budget.

Medicaid reimbursement to home health providers doesn't cover the costs associated with caring for this growing and challenging population. Compounding unreasonable audit practices on top of this underfunding is causing home health providers to reconsider doing business with the State and caring for these Medicaid clients.

Thank you for the opportunity to testify and I am available to respond to your questions.

Deborah Hoyt 203-774-4939 hoyt@cthealthcareathome.org